Application for Physical Disabilities Services

Personal Data

Name:		Date of Birth:	
Address:	City:	State:	Zip:
Social Security #:	Home Phone:( )-	Work Phone:( )-	

Present living situation: ☐ House ☐ Apartment ☐ Nursing home ☐ Other (explain):

Description of Disabling Condition

Nature of disability:

Is this condition: ○ Temporary or ○ Permanent	Date of onset:

If temporary, please clarify as to duration:

Do you have a Medicaid Card? ○ Yes ○ No	What is your monthly income? $

Are you eighteen (18) years of age or older? ○ Yes ○ No

Do you require the assistance of another person to accomplish activities of daily living due to a functional loss of two (2) or more limbs? ○ Yes ○ No

Please check the number of hours of assistance you need each day

○ 2-3 hours per day from a personal attendant to assist with **dressing, grooming, meal preparation, laundry, shopping, and eating**.

○ 4-5 hours per day from a personal attendant to assist with **transferring, bathing/showering, range of motion exercises, transportation, food consumption, and assistance with bodily functions** in addition to dressing, grooming, meal preparation, laundry, shopping, and eating.

○ more than 5 hours per day from a personal attendant to assist with **tasks requiring skilled or medically sensitive services such as respirator and catheter care, suctioning, or overnight attention** in addition to dressing, grooming, meal preparation, laundry, shopping, eating, transferring, bathing/showering, range of motion exercises, transportation, food consumption, and assistance with bodily functions.

Total number of hours per week of personal assistance requested:

How will receiving Physical Disabilities Services alleviate a "dependent" living situation?

Person's Verification

I understand that due to fiscal limits my name may be placed on a waiting list. I understand that if I am found to be eligible only to receive state (non-Medicaid) funding, that my monthly benefit amount may be constrained. I also understand that if my needs change or I feel my circumstances warrant a higher priority on the waiting list that I may petition the Nurse Coordinator. I verify that the information I have provided in this application is true and accurate. I agree to comply with all program requirements and I agree to use funds only to purchase physical disabilities services.

Signature:	**Date:**

Application for Physical Disabilities Services

Primary physician's name:_____ Phone:
Address:

Physician's Recommendation

Dear Physician: Your patient is applying for Physical Disabilities Services through the Division of Services for People with Disabilities. Physical Disabilities Services means hands-on care, of both a medical (to the extent permitted by State law) and non-medical supportive nature specific to the needs of an adult with a physical disability. Please take a few minutes to complete this page. The information you provide will assist the Division Nurse Coordinator in making a determination of whether your patient is eligible for service.

In order to qualify for Physical disabilities services an individual must:
(a) be capable of directing all aspects of his or her care, and
(b) due to a functional loss of 2 or more limbs require the assistance of another person to accomplish activities of daily living (e.g., dressing, grooming, meal preparation, laundry, shopping, eating, transferring, bathing/showering, range of motion exercises, transportation, food consumption, assistance with bodily functions**,** respirator, catheter care, suctioning, or overnight attention).

Name of patient:

Patient's diagnosis:

○ **Yes** ○ **No** **In my opinion the patient is capable of hiring, training and supervision his or her personal attendant and managing his or her financial and legal affairs.**

If No, Please Explain:

○ **Yes** ○ **No** The Person has a functional loss of 2 or more limbs; this functional loss requires assistance of another person to accomplish activities of daily living.

Please indicate the number of hours per day of personal assistance you believe the patient requires:

○ **none.**
○ **2-3 hours per day.**
○ **4-5 hours per day.**
⊙ **more than 5 hours per day.**

Physician's Verification

I certify that the information I have provided on the application is true and correct to the best of my knowledge.

Physician's Signature:	**Date:**

Comments:

Return Completed Form to:
Division of Services for People With Disabilities
attn: Nurse Coordinator
120 North 200 West Rm 411
Salt Lake City, Utah 84103

FOR DIVISION OFFICE STAFF ONLY
STAMP DATE RECEIVED IN BOX